DDD-1279AFORPF (12-05)

Clear The Form

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

CASE TRANSFER

CLIENT'S INFORMATION

INDIVIDUAL'S NAME *(Last, First, M.I.)*	ASSISTS ID		DATE OF BIRTH
ADDRESS *(No., Street, City, State, ZIP)*	AREA CODE AND PHONE NO.		PRIMARY LANGUAGE
TRANSFER SUPPORT COORDINATOR/SUPERVISOR	SITE CODE	WORKER ID NO.	DATE TRANSFER
RECEIVING SUPPORT COORDINATOR/SUPERVISOR	SITE CODE	WORKER ID NO.	DATE RECEIVED

RECEIVING SUPPORT COORDINATOR/SUPERVISOR:

Update ASSISTS Worker ID/Office ID ☐ Yes ☐ No

Update Support Coordinator in RIMS *(Verify Client Information Screen)* ☐ Yes ☐ No

ELIGIBILITY

ALTCS Eligibility: ☐ Eligible ☐ State ONLY Eligibility ☐ Application Pending

DDD DIAGNOSIS

Targeted Support Coordination ☐ Yes ☐ No | Type: | Frequency:

Division Development Disabilities Re-determination completed? ☐ Yes ☐ No ☐ Pending ☐ N/A

CURRENT SERVICES/PROGRAMS

RESIDENTIAL	ADDRESS *(No., Street, City, State, ZIP)*	AREA CODE AND PHONE NO.
DAY PROGRAM	ADDRESS *(No., Street, City, State, ZIP)*	AREA CODE AND PHONE NO.
EMPLOYER	ADDRESS *(No., Street, City, State, ZIP)*	AREA CODE AND PHONE NO.
SCHOOL	ADDRESS *(No., Street, City, State, ZIP)*	AREA CODE AND PHONE NO.

Other Residential Placement for Educational Reasons (A.R.S. 15): ☐ Yes ☐ No

PRESENT SITUATION

☐ Stable
☐ Unstable Explain:

Any open UIR's / IR's on RIMS? ☐ Yes ☐ No | REPORT NO.(S)

Follow-up Needed *(Including referrals, DME, Aug Com, etc.)*

DATE OF LAST ISP	DATE OF LAST QUARTERLY REVIEW	DATE OF LAST QBHP REVIEW

QBHP's NAME *(First, Middle, Last)*

Behavior Program? ☐ Yes ☐ No | Program Review Committee involved? ☐ Yes ☐ No | DATE OF LAST PRC REVIEW

Medications? ☐ Yes ☐ No

If yes, does the individual have sufficient medications to last until next doctor's appointment? ☐ Yes ☐ No

Other Agencies Involved: *(e.g. APS, CPS, CRS, RHBA, Public Fiduciary, Tribal, Law Enforcement, etc.)*

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INDIVIDUAL'S NAME *(Last, First, M.I.)*	ASSISTS ID	DATE OF BIRTH

CHECKLIST

		DATE COMPLETED
Client/Family notified of transfer:	☐ Yes ☐ No ☐ N/A	
Transfer progress note completed:	☐ Yes ☐ No ☐ N/A	
ALTCS Change form:	☐ Yes ☐ No ☐ N/A	
Mailed to local ALTCS office	☐ Yes ☐ No ☐ N/A	
Copy mailed to managed care	☐ Yes ☐ No ☐ N/A	
Regional Behavioral Health Authority notified:	☐ Yes ☐ No ☐ N/A	
Client primary record updated *(printed/filed)*:	☐ Yes ☐ No ☐ N/A	
Significant other screen updated *(printed/filed)*:	☐ Yes ☐ No ☐ N/A	
Benefits and evaluation screen updated *(printed/filed)*:	☐ Yes ☐ No ☐ N/A	
Service plan screen updated *(printed/filed)*:	☐ Yes ☐ No ☐ N/A	
DDD billing information form completed For residential clients (DD-090):	☐ Yes ☐ No ☐ N/A	
Review current authorizations/scripts (ATF, CLS, SPP)	☐ Yes ☐ No ☐ N/A	

ADDITIONAL INFORMATION